history of the corpus luteum it is clear that there are three stages and in each stage profuse hæmorrhage may occur.

The first stage.—The time of ovulation. The ovum is expelled and the granulosa cells take on lutein characters. At this time it is not uncommon for serious hæmorrhage to occur from the ripe Graafian follicle, several cases of which have been reported.

The second stage.—Active growth of the corpus luteum takes place between the time of ovulation (usually the 14th day) and the 19th day of the cycle, taking the first day of the menstrual period to be the beginning of the cycle. Here we get the large lutein cells packed tightly together, forming the typical yellow coloured convolution, and the smaller theca interna cells scattered at the periphery and entering the septa of the lutein convolution.

Third stage.—The corpus luteum persists in its mature state and is responsible for producing the changes in the uterus preparatory to the embedding of the fertilized ovum, and the richly lipoid body which is found in the old luteal hæmatoma just as the next menstrual period commences.

There is really a *fourth stage*—the gradual replacement of the corpus luteum by hyaline tissue forming the corpus albicans, it taking in all nine months for the lutein cells to disappear entirely.

It was at the end of the second stage, or the beginning of the third stage, of the life history of the corpus luteum that the serious hæmorrhage occurred in the case I am about to report.

Mrs. P., housewife, aged 39, VI—gr., 11—para, was admitted March 29, 1929, complaining of severe right-sided lower abdominal pain and of feeling faint. The first day of her last menstrual period, which was normal in its duration and flow, had been March 9, 1929. Her appendix had been previously removed.

On examination, her temperature was 98.4°; pulse 140 and thready. A catheter specimen of urine was negative for red blood cells, white blood cells and casts. The patient was waxy in appearance and her abdomen was tender in the right lower quadrant and rigid over the entire lower part, more so on the right side than on the left. No free fluid could be made out. Vaginal examination under an anæsthetic showed no urethral or cervical discharge. The uterus was forward and normal. The fornices appeared clear.

Posterior colpotomy disclosed much blood. On opening the abdomen nearly a pint of blood escaped, and the blood was found to be coming from the right ovary, which was removed. The right tube, uterus, left tube and ovary, appeared to be normal, there being no adhesions or any sign of a previous inflammatory process. The patient made an uninterrupted recovery.

Pathological report.—"The ovary is normal in size. At one pole is a small clot protruding from a ruptured corpus luteum. Microscopic: the ovary contains many large corpora albicantia and a well developed luteal hæmatoma which has ruptured. Sections showed no evidence of chronic ovaritis."

REMARKS

The causes given for such a condition are:—

1. Injury.—There was no history of trauma as the patient was awakened from her sleep with the pain.

2. Previous infection.—Section of the ovary showed no inflammatory change.

3. An exceedingly vascular organ.—This is a possible cause, as the rupture occurred just before the next period was due.

4. Rupture through the weakened spot caused by extrusion of the Graafian follicle. This may be the case here, as the rupture occurred in that part of the hæmatoma where the ovarian tissue was thinnest.

I desire to express my thanks to Dr. P. L. Irvine, of Toronto, to whom I am indebted for the case.

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AN OVERLOOKED CASE OF SCURVY

BY J. C. DIAMOND, M.D.,

Fort William, Ont.

I was called to see a little girl of four years of age. The mother gave a history that the child had been in perfect health until six months before, when she became "cranky" on account of a toothache and was given a push by the mother. The child fell and could not use her legs. She was taken to several doctors

but treatment did not help. She next went to a chiropractor who "set her spine" and "replaced her hips," but still the child refused to walk.

When I was called to see her, she was lying on her back, with her knees acutely flexed, and the muscles of the thighs, legs, and buttocks badly wasted. The child screamed with pain whenever one attempted to touch her legs. Everything else was normal, except that her teeth had all been extracted. On asking why they were extracted, her mother said that they were very bad and her gums were swollen, and a doctor had told her that the child was suffering from rheumatism caused by these bad teeth. The teeth were extracted but she was not any better.

I made a diagnosis of scurvy and placed the child on orange juice and on the third day she was on her legs without pain. Massage and heat were applied to the legs, and the child was walking after two weeks' time.

AN "ANCIENT" CASE OF EMPYEMA OF THE FRONTAL SINUS

BY J. PRICE BROWN, M.B.,

Toronto

A young lady consulted me about twenty years ago. She was bright and had a good complexion, but she had frontal sinus disease. The whole of the right side of the head was swollen and red. I examined the nose internally and could find no discharge of pus coming from the sinus. The question was, what to do. I arrived at the conclusion that there was perhaps an abscess forming there, and that it ought to be drained. One of the leading Chicago specialists at that time was Dr. Ingles, who advocated using a silver tube in frontal sinus cases, passing it through the sinus into the nose. I had the idea of the tube in mind and I thought if the sinus were opened and a silver tube passed into the nose the patient might recover. So I had one made before I operated. To give you an idea of what the condition was, the surface over the sinus was much swollen and inflamed. After chiselling into the bone in a line with the eyebrow, a surgeon standing by said. "That is a case of sarcoma." I said it could not be. There was considerable pus in the cavity and some induration. I curetted it out, drilled into the nose, and passed the tube down through the sinus into the nasal cavity, leaving it in position. Then I thoroughly sterilized the cavity and sewed up the outside completely. The patient recovered and there was scarcely perceptible deformity, the eyebrow covering the scar in large measure. After the healing of the wound and the removal of the tube through the nose there was no return whatever of the sinus disease.

At that time I did not know much about frontal sinus disease and its connection with osteomyelitis, but I knew there was infection there, and that was the result.

[The above Case Report formed part of a discussion, to which Dr. Price Brown contributed, on Dr. Skillern's paper at the meeting of the American Laryngological, Rhinological, and Otological Society held in San Francisco early in July last year. It has been forwarded to the *Journal*, together with a very interesting letter, by Dr. Brown.

Dr. J. Price Brown, of Toronto, is well known to the older generation of medical men, at least, as a specialist in oto-laryngology. His text-book on "Diseases of the Nose and Throat", published thirty years ago, was a recognized authority on the subject, and was on the recommended list of books at Toronto University and the New York Polyclinic. He also entered the realm of fiction, bringing out during the next five years four novels dealing with Canadian life—Hickory of the Lakes; How Hartman won; In the Van; and The Macs of '37.

Dr. Brown has been retired from active work for fifteen years, during ten of which, unfortunately, he has been blind. Despite his handicap and his advanced years he was able to attend the meeting above referred to, where he was received with acclamation, and took part in the discussion of several of the papers.—ED.]

INFLAMMABLE THROAT LOZENGES.—Dr. J. Pereira Gray writes: A policeman on cycle patrol duty felt a slight sore throat. He bought some chlorate of potash lozenges and put them in his trousers pocket, which contained a box of safety matches. After cycling for a few minutes he thought he heard a slight explosion; a minute later he saw flames issuing, which burnt a large hole in his pants and trousers, caught his coat and waistcoat, and scorched his skin in several places. He managed to extinguish the flames, and, on investigating their cause, he noticed that the live heads of his matches were now dead and his lozenges had disappeared. This episode shows that if potassium chlorate lozenges and safety matches are carried about they should not be placed in the same pocket. . . . The danger is not so much from the match heads as from the red phosphorus on the box, as anyone can prove by gently rubbing a chlorate of potassium lozenge along the side of an empty safety matchbox.—*Brit. M. J.*, Nov. 23, 1929.